APPLICATION FOR LICENSURE AS A MENTAL HEALTH COUNSELOR (LMHC)

State Form 50319 (R / 1-02)
Approved by State Board of Accounts, 2002

SOCIAL WORKER, MARRIAGE AND FAMILY THERAPIST AND MENTAL HEALTH COUNSELOR BOARD

*** Your Social Security number is being requested by this state agency in accordance with I.C. 4-1-8-1. Disclosure is mandatory, and this record cannot be processed without it.**

FOR OFFICE USE ONLY	
APPLICATION FEE:	
DATE FEE PAID:	
RECEIPT NUMBER:	
LICENSE NUMBER ISSUED:	
PERMIT NUMBER ISSUED:	
DATE LICENSE ISSUED:	

Attach One Passport Quality Photograph Here (*See Instructions*)

APPLICANT INFORMATION

Name (*last, first, middle, maiden or previous*)

Current address (*number, street or Rural Route*)

City	**State**	**ZIP code**

Permanent address (*IF DIFFERENT FROM ADDRESS ABOVE*)

City	**State**	**ZIP code**

Work telephone number (*include area code*)	**Home telephone number** (*include area code*)

Social Security number *	**Date of birth** (*month, day, year*)	**Place of birth** (*city, state*)

E-mail address

Are you applying for a temporary permit?

☐ Yes ☐ No

Please indicate exactly how you wish your name to appear on your license.

Please check all that apply:

☐ I am applying for licensure by examination.

☐ I am applying for licensure by exemption from the examination (ENDORSEMENT).

☐ I am currently licensed / certified in another state.
Type of licensure / certification _____
Issued by (*name of State Board*) _____
OR

☐ I have been engaged in the practice of mental health counseling for not less than three of the previous five years and have completed Form EE of this application.
AND
I successfully passed the NCMHCE examination.
Date: _____ State: _____
OR
I have passed the (*name of examination*)
_____
Date: _____ State: _____

NOTE: To qualify for licensure through exemption from examination, you must meet A **or** B **and** C below.

A. You must either be currently licensed / certified to practice mental health counseling in another state; **OR**
B. You must have been engaged in the practice of mental health counseling for not less than three of the previous five years; **AND**
C. You must have successfully passed the NCMHCE or an equivalent clinical examination.

GRADUATE EDUCATION (*Master's or Doctoral*)		
Name of academic institution:	Department	Program title
Location (*city and state*)	Dates attended (*month, year to month, year*)	Degree earned
Name of academic institution:	Department	Program title
Location (*city and state*)	Dates attended (*month, year to month, year*)	Degree earned
Name of academic institution:	Department	Program title
Location (*city and state*)	Dates attended (*month, year to month, year*)	Degree earned

EMPLOYMENT HISTORY FOR THE PAST FIVE (5) YEARS		
Please list all places of professional employment, including self-employment.		
Name of employer	Position or title	Name of supervisor
Location (*city and state*)	Dates employed (*month, year to month, year*)	Average hours per week
Duties or responsibilities		
Name of employer	Position or title	Name of supervisor
Location (*city and state*)	Dates employed (*month, year to month, year*)	Average hours per week
Duties or responsibilities		
Name of employer	Position or title	Name of supervisor
Location (*city and state*)	Dates employed (*month, year to month, year*)	Average hours per week
Duties or responsibilities		
Name of employer	Position or title	Name of supervisor
Location (*city and state*)	Dates employed (*month, year to month, year*)	Average hours per week
Duties or responsibilities		
Name of employer	Position or title	Name of supervisor
Location (*city and state*)	Dates employed (*month, year to month, year*)	Average hours per week
Duties or responsibilities		
Name of employer	Position or title	Name of supervisor
Location (*city and state*)	Dates employed (*month, year to month, year*)	Average hours per week
Duties or responsibilities		

OTHER STATE LICENSURE / CERTIFICATION

Do you now hold, or have you ever held, a license / certification / registration / permit to practice any regulated health profession by a state licensing board? ☐ Yes ☐ No

(*If yes, list all states below, including Indiana, in which you have held a license / certification / registration / permit to practice any state regulated health occupation*.)

TYPE OF LICENSE / CERTIFICATE / REGISTRATION / PERMIT	STATE	LICENSE NUMBER	DATE ISSUED	STATUS
1.				
2.				
3.				
4.				
5.				

If your answer is "Yes" to any of the following, explain fully in a signed and notarized statement, including all related details. Include the violation, location, date and disposition. If malpractice, provide name(s) of plantiff(s). Letters from attorneys or insurance companies are not accepted in lieu of your statement. Falsification of any of the following is grounds for permanent revocation of a license or permit issued pursuant to this application.

1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held? ☐ Yes ☐ No
2. Have you ever been denied a license, certificate, registration or permit to practice medicine, osteopathic medicine or any regulated health occupation in any state *(including Indiana)* or country? ☐ Yes ☐ No
3. Are you now being, or have you ever been treated for a drug abuse or alcohol problem? ☐ Yes ☐ No
4. Have you ever been charged with drug addiction? ☐ Yes ☐ No
5. Have you ever been convicted of, pled guilty or *nolo contendre* to:
   A. A violation of any Federal, State or local law relating to the use, manufacturing, distribution or dispensing of controlled substances or drug addiction? ☐ Yes ☐ No
   B. Any offense, misdemeanor or felony in any state? *(Except for minor violations of traffic laws resulting in fines)* ☐ Yes ☐ No
6. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations? ☐ Yes ☐ No
7. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant? ☐ Yes ☐ No
8. Have you ever had a malpractice judgement against you or settled any malpractice action? ☐ Yes ☐ No

APPLICATION AFFIRMATION

I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct.

Signature of applicant	Date signed (*month, day, year*)

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, corporation, association, organization or institution to release to the Health Professions Bureau of Indiana, or Indiana Social Worker, Marriage and Family Therapist and Mental Health Counselor Board, any files, documents, records or other information pertaining to the undersigned requested by the Bureau, or the Board, or any of their authorized representatives in connection with processing my application for licensure.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Health Professions Bureau of Indiana, or the Indiana Social Worker, Marriage and Family Therapist and Mental Health Counselor Board, to disclose to the aforementioned persons, firms, officers, corporations, associations, organizations, and institutions any information which is material to my application, and I hereby specifically release the Bureau, and the Board from any and all liability in connection with such disclosures.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I hereby swear or affirm, that I have read the above statements and agree to same.

Signature of applicant	Date signed (*month, day, year*)

FORM C
VERIFICATION OF GRADUATE COURSEWORK FOR LICENSURE AS A MENTAL HEALTH COUNSELOR

State Form 50319 (R / 1-02)

In addition to this form, an official transcript from your degree granting institution and any other educational institutions at which you may have completed coursework or clinical experience must be sent directly from the institution(s) to the Health Professions Bureau. Delays in the application approval process are often the result of the Board's need to obtain more information from applicants regarding the specifics of individual course content. In order to ensure expediency in the application approval process, the Board suggests, but does not require, that applicants submit course catalog descriptions or course syllabi to accompany Form C.

COURSEWORK INFORMATION

List the course number and course title of the graduate coursework you have completed in the required content areas as they appear on your transcript. If the course titles as stated on your transcript do not clearly reflect the required content areas, you may be requested to provide additional supporting documentation such as course syllabus, term papers, etc. You may use the same course for more than one content area. Also, each content area may contain more than one course. Please use FORM C-1 to assist you in determining which courses to list in each content area.

HUMAN GROWTH AND DEVELOPMENT

Name of Educational Institution	Course Number	Course Title	Credit Hours	Semester / Quarter
				Semester _____ Quarter _____

SOCIAL AND CULTURAL FOUNDATIONS

Name of Educational Institution	Course Number	Course Title	Credit Hours	Semester / Quarter
				Semester _____ Quarter _____

HELPING RELATIONSHIPS

Name of Educational Institution	Course Number	Course Title	Credit Hours	Semester / Quarter
				Semester _____ Quarter _____

GROUP WORK

Name of Educational Institution	Course Number	Course Title	Credit Hours	Semester / Quarter
				Semester _____ Quarter _____

CAREER AND LIFESTYLE DEVELOPMENT

Name of Educational Institution	Course Number	Course Title	Credit Hours	Semester / Quarter
				Semester _____ Quarter _____

APPRAISAL

Name of Educational Institution	Course Number	Course Title	Credit Hours	Semester / Quarter
				Semester _____ Quarter _____

RESEARCH AND PROGRAM EVALUATION

Name of Educational Institution	Course Number	Course Title	Credit Hours	Semester / Quarter
				Semester _____ Quarter _____

PROFESSIONAL ORIENTATION

Name of Educational Institution	Course Number	Course Title	Credit Hours	Semester / Quarter
				Semester _____ Quarter _____

FOUNDATIONS OF MENTAL HEALTH COUNSELING

Name of Educational Institution	Course Number	Course Title	Credit Hours	Semester / Quarter
				Semester _____ Quarter _____

CONTEXTUAL DIMENSIONS

Name of Educational Institution	Course Number	Course Title	Credit Hours	
				Semester _____ **Quarter** _____

KNOWLEDGE AND SKILLS FOR THE PRACTICE OF MENTAL HEALTH COUNSELING

Name of Educational Institution	Course Number	Course Title	Credit Hours	
				Semester _____ **Quarter** _____

Applicants for licensure as a mental health counselor must show successful completion of a degree curriculum which shall encompass a minimum of forty-eight (48) semester hours, or seventy-two (72) quarter hours, of graduate study for the master's degree or a minimum of ninety-six (96) semester hours of graduate study for the doctoral degree. Further, the applicant for licensure shall document a minimum of sixty (60) hours of graduate credit in mental health counseling or a related field. Only graduate level courses are acceptable. The board will not accept coursework counted or credited toward an undergraduate degree.

Applicants for licensure as a mental health counselor must also show successful completion of a one hundred (100) hour practicum, a six hundred (600) hour internship and a three hundred (300) hour advanced internship. Please list these requirements below.

PRACTICUM

Name of Educational Institution	Course Number	Course Title	Credit Hours	
				Semester _____ **Quarter** _____

INTERNSHIP

Name of Educational Institution	Course Number	Course Title	Credit Hours	
				Semester _____ **Quarter** _____

ADVANCED INTERNSHIP

Name of Educational Institution	Course Number	Course Title	Credit Hours	
				Semester _____ **Quarter** _____

Signature of applicant	Date (*month, day, year*)
Printed name of applicant	Social Security number *

FORM C-1
GRADUATE COURSEWORK CONTENT AREAS

State Form 50319 (R / 1-02)

HUMAN GROWTH AND DEVELOPMENT

Studies that provide an understanding of the nature and needs of individuals at all developmental levels.

A. Theories of individual and family development and transitions across the life-span;

B. Theories of learning and personality development;

C. Human behavior including an understanding of developmental crises, disability, addictive behavior, psychopathology, and environmental factors as they affect both normal and abnormal behavior;

D. Strategies for facilitating development over the life span.

SOCIAL AND CULTURAL FOUNDATIONS

Studies that provide an understanding of issues and trends in a multicultural and diverse society.

A. Multicultural and pluralistic trends including characteristics and concerns of diverse groups;

B. Attitudes and behavior based on such factors as age, race, religious preference, physical disability, sexual orientation, ethnicity and culture, family patterns, gender, socioeconomic status, and intellectual ability;

C. Individual, family, and group strategies with diverse populations.

HELPING RELATIONSHIPS

Studies that provide an understanding of counseling and consultation processes.

A. Counseling and consultation theories including both individual and systems perspectives as well as coverage of relevant research and factors considered in applications;

B. Basic interviewing, assessment, and counseling skills;

C. Counselor or consultant characteristics and behaviors that influence helping processes including age, gender and ethnic differences, verbal and nonverbal behaviors and personal characteristics, orientations, and skills;

D. Client or consultee characteristics and behaviors that influence helping processes including age, gender and ethnic differences, verbal and nonverbal behaviors and persona characteristics, traits, capabilities, and life circumstances.

GROUP WORK

Studies that provide an understanding of group development, dynamics, counseling theories, group counseling methods and skills, and other group work approaches.

A. Principles of group dynamics including group process components, developmental stage theories, and group members' roles and behaviors;

B. Group leadership styles and approaches including characteristics of various types of group leaders and leadership styles;

C. Theories of group counseling including commonalities, distinguishing characteristics, and pertinent research and literature;

D. Group counseling methods including group counselor orientations and behaviors, ethical standards, appropriate selection criteria and methods, and methods of evaluation of effectiveness;

E. Approaches used for other types of group work, including task groups, prevention groups, support groups, and therapy groups.

CAREER AND LIFESTYLE DEVELOPMENT

Studies that provide an understanding of career development and related life factors.

A. Career development theories and decision-making models;

B. Career, avocational, educational, and labor market information resources, visual and print media, and computer-based career information systems;

C. Career development program planning, organization, implementation, administration, and evaluation;

D. Interrelationships among work, family, and other life roles and factors including multicultural and gender issues as related to career development;

E. Career and educational placement, follow-up and evaluation;

F. Assessment instruments and techniques relevant to career planning and decision-making;

G. Computer based career development applications and strategies, including computer-assisted career guidance systems;

H. Career counseling processes, techniques and resources including those applicable to specific populations.

APPRAISAL

Studies that provide an understanding of individual and group approaches to assessment and evaluation.

A. Theoretical and historical bases for assessment techniques;

B. Validity including evidence for establishing content, construct, and empirical validity;

C. Reliability including methods of establishing stability, internal and equivalence reliability;

D. Appraisal methods including environmental assessment, performance assessment, individual and group test and inventory methods, behavioral observations, and computer-managed and computer-assisted methods;

E. Psychometric statistics including types of assessment scores, measures of central tendency, indices of variability, standard errors, and correlations;

F. Age, gender, ethnicity, language, disability, and culture factors related to the assessment and evaluation of individuals and groups;

G. Strategies for selecting, administering, interpreting, and using assessment and evaluation instruments and techniques in counseling.

RESEARCH AND PROGRAM EVALUATION

Studies that provide an understanding of types of research methods, basic statistics, and ethical and legal considerations in research..

A. Basic types or research methods to include qualitative and quantitative research designs;

B. Basic parametric and non parametric statistics;

C. Principles, practices, and applications of need assessment and program evaluation;

D. Uses of computers for data management and analysis.

PROFESSIONAL ORIENTATION

Studies that provide an understanding of all aspects of professional functioning including history, roles, organizational structures, ethics, standards, and credentialing.

A. History of the helping professions including significant factors and events;

B. Professional roles and functions including similarities and differences with other types of professionals;

C. Professional organizations, primarily ACA, its divisions, branches, and affiliates, including membership benefits, activities, services to members, and current emphases;

D. Ethical standards of the ACA and related entities, ethical and legal issues, and their applications to various professional activities (*e.g., appraisal, group work*);

E. Professional preparation standards, their evolution, and current applications;

F. Professional credentialing including certification, licensure, and accreditation practices and standards, and the effects of public policy on these issues; and

G. Public policy processes including the role of the professional counselor in advocating on behalf of the profession and its clientele.

FOUNDATIONS OF MENTAL HEALTH COUNSELING

Studies in this area include, but are not limited to, the following:

A. Historical, philosophical, societal, cultural, economic, and political dimensions of mental health counseling;

B. Roles, functions, and professional identity of mental health counselors;

C. Structures and operations of professional organizations, training standards credentialing bodies, and ethical codes pertaining to the practice of mental health counseling;

D. Implications of professional issues unique to mental health counseling including, but not limited to, recognition, reimbursement, right to practice, core provider status, access to and practice privileges within managed care systems, and expert witness status; and

E. Implications of sociocultural, demographic, and lifestyle diversity relevant to mental health counseling.

CONTEXTUAL DIMENSIONS: MENTAL HEALTH COUNSELING

Studies in this area include, but are not limited to, the following:

A. Assumptions and roles of mental health counseling within the context of the health and human services systems, including functions and relationships among interdisciplinary treatment teams, and the historical, organizational, legal, and fiscal dimensions of the public and private mental health care systems;

B. Theories and techniques of community needs assessment to design, implement, and evaluate mental health care programs and systems;

C. Principles, theories, and practices of community intervention, including programs and facilities for inpatient, outpatient, partial treatment, and aftercare, and the human services network in local communities; and

D. Theoretical and applied approaches to administration, finance and budgeting; management of mental health services and programs in the public and private sectors; principles and practices for establishing and maintaining both solo and group private practice; and concepts and procedures for determining accountability and cost containment.

KNOWLEDGE AND SKILLS FOR THE PRACTICE OF MENTAL HEALTH COUNSELING

Studies in this area include, but are not limited to, the following:

A. General principles of etiology, diagnosis, treatment, and prevention of mental and emotional disorders and dysfunctional behavior, and general principles and practices of the promotion of optimal mental health;

B. Specific models and methods for assessing mental status; identification of abnormal, deviant, or psychopathological behavior, and the interpretation of findings in current diagnostic categories [*e.g., Diagnostic and Statistical Manual (DSM)*];

C. Application of modalities for maintaining and terminating counseling and psychotherapy with mentally and emotionally impaired clients, including crisis intervention, brief, intermediate, and long-term approaches;

D. Basic classifications, indications, and contraindications of commonly prescribed psychopharmacological medications for the purpose of identifying effects and side effects of such medications;

E. Principles of conducting an intake interview and mental health history for planning and managing of client caseload;

F. Specialized consultation skills for effecting living and work environments to improve relationships, communications and productivity, and for working with counselors of different specializations and with other mental health professionals in areas related to collaborative treatment strategies;

G. The application of concepts of mental health education, consultation, outreach and prevention strategies, and of community health promotion and advocacy; and

H. Effective strategies for influencing public policy and government relations on local, state, and national levels to enhance funding and programs affecting mental health services in general and the practice of mental health counseling in particular.

FORM P
VERIFICATION OF PRACTICUM FOR LICENSURE AS A MENTAL HEALTH COUNSELOR (LMHC)

State Form 50319 (R / 1-02)

Complete **SECTION A** and then forward this form to the educational institution at which you have completed your practicum.

SECTION A / APPLICANT INFORMATION

Name of applicant (*last, first, middle, maiden*)	Social Security number *

My minimum one hundred (100) hour practicum was completed under the auspices of the following educational institution:

_____ located at _____

(*Name of Institution*) (*City and State*)

I completed the practicum between the following dates:

_____ _____

Date began (*Month/Year*) Date completed (*Month/Year*)

I completed the practicum at the following location:

_____

(*Specific location of practicum*)

SECTION B / VERIFICATION OF COMPLETION OF THE ONE HUNDRED (100) HOUR PRACTICUM

SECTION B must be completed by an official of the institution that has granted you the academic credit for this supervised clinical experience.

As an official of the school named above. I certify, that the above-named applicant has completed at least the following experience during the completion of the practicum:

(1) Applicant has completed at least a one hundred (100) hour practicum that enabled the applicant to develop basic counseling skills and to integrate professional knowledge and skills appropriate to the applicant's program emphasis.

(2) Applicant has completed a minimum of forty (40) hours of direct service with clients during this practicum and at least one fourth (1/4) of the hours were completed in group work.

As an official of the school named above, I certify that the above-named applicant did receive the following supervision during the completion of the practicum: Applicant received a minimum of one (1) hour per week of individual supervision and a minimum of one and one-half (1 1/2) hours per week of group supervision with other students over a minimum of one (1) academic term. For the purposes of this certification, individual supervision is defined as supervision rendered to one (1) person at a time, and group supervision is supervision rendered to at least two (2) and not more than twelve (12) individuals at one (1) time. During the completion of this practicum, the applicant did receive the following number of hours of face-to-face supervision: _____

I further certify that the supervision for this practicum was conducted by either a program faculty member or a supervisor working under the supervision of a program faculty member using audiotape, videotape and / or direct observation. The applicant's supervisor(s) held the following position(s), degree(s), license(s), and / or certification(s) - [*Provide name(s) and qualification(s) below*]:

Program faculty member:

Alternate supervisor:

Site supervisor:

Additionally, I certify the applicant's performance was evaluated throughout the practicum and a formal evaluation was performed at the conclusion of the practicum by the program faculty supervisor, in consultation with the site supervisor, if applicable.

I hold the following position at:

Position held at the institution:	Name of institution

Name (*last, first, middle, maiden or previous name*)

RETURN THIS FORM TO:
Health Professions Bureau
402 West Washington Street, Room 041
Indianapolis, IN 46204

FORM I
VERIFICATION OF INTERNSHIP FOR LICENSURE AS A MENTAL HEALTH COUNSELOR (LMHC)

State Form 50319 (R / 1-02)

Complete **SECTION A** and then forward this form to the educational institution at which you have completed your internship.
SECTION B must be completed by an official of the institution that has granted you the academic credit for this supervised clinical experience.

SECTION A / APPLICANT INFORMATION

Name of applicant (*last, first, middle, maiden*)	Social Security number *

My minimum six hundred (600) hour internship was completed under the auspices of the following educational institution:

_____ located at _____
(*Name of Institution*) (*City and State*)

I completed the internship between the following dates:

_____ _____
Date began (*Month/Year*) Date completed (*Month/Year*)

I completed the internship at the following location:

_____
(*Specific location of practicum*)

SECTION B / VERIFICATION OF COMPLETION OF THE SIX HUNDRED (600) HOUR INTERNSHIP

As an official of the school named above. I certify, that the above-named applicant has completed at least the following experience during the completion of the internship:

(1) Applicant has completed at least a six hundred (600) hour internship that enabled the applicant to refine and enhance basic counseling skills, to develop more advanced counseling skills and to integrate professional knowledge and skills appropriate to the student's initial post graduation professional placement.
(2) Applicant has completed a minimum of two hundred forty (240) hours of direct service with clients appropriate to the program of study.
(3) Additionally, the applicant was provided with the following opportunities:
(a) for the student to become familiar with a variety of professional activities other than direct service.
(b) for the student to develop audiotapes and/or videotapes of the student's interactions with clients appropriate for use in supervision.
(c) for the student to gain supervised experience in the use of a variety of professional resources, such as, assessment instruments; computers; print and nonprint media; professional literature; research; and information and referral to appropriate providers.

As an official of the school named above, I certify that the above-named applicant did receive the following supervision during the completion of the internship: Applicant received a minimum of one (1) hour per week of individual supervision and a minimum of one and one-half (1 1/2) hours per week of group supervision, throughout the internship. For the purposes of this certification, individual supervision is defined as supervision rendered to one (1) person at a time, and group supervision is supervision rendered to at least two (2) and not more than twelve (12) individuals at one (1) time. During the completion of this internship, the applicant did receive the following number of hours of face-to-face supervision: _____

I further certify that the supervision for this internship was conducted by either a program faculty member or a supervisor working under the supervision of a program faculty member using audiotape, videotape and/or direct observation. The applicant's supervisor(s) held the following position(s), degree(s), license(s), and/or certification(s) - [*Provide name(s) and qualification(s) below*]:

Program faculty member:
Alternate supervisor:
Site supervisor:

Additionally, I certify the applicant's performance was evaluated throughout the internship and a formal evaluation was performed at the conclusion of the internship by the program faculty supervisor, in consultation with the site supervisor, if applicable.

I hold the following position at:

Position held at the institution:	Name of institution

Name (*last, first, middle, maiden or previous name*)

RETURN THIS FORM TO:
Health Professions Bureau
402 West Washington Street, Room 041
Indianapolis, IN 46204

FORM AI
VERIFICATION OF ADVANCED INTERNSHIP FOR LICENSURE AS A MENTAL HEALTH COUNSELOR

State Form 50319 (R / 1-02)

Complete **SECTION A** and then forward this form to the educational institution at which you have completed your advanced internship.
SECTION B must be completed by an official of the institution that has granted you the academic credit for this supervised clinical experience.

SECTION A / APPLICANT INFORMATION

Name of applicant (*last, first, middle, maiden*)	Social Security number *

My minimum three hundred (300) hour advanced internship was completed under the auspices of the following educational institution:

_____ located at _____
(*Name of Institution*) (*City and State*)

I completed the advanced internship between the following dates:

_____ _____
Date began (*Month/Year*) Date completed (*Month/Year*)

I completed the advanced internship at the following location:

_____
(*Specific location of practicum*)

SECTION B / VERIFICATION OF COMPLETION OF THE THREE HUNDRED (300) HOUR ADVANCED INTERNSHIP

As an official of the school named above, I certify that the above-named applicant has completed at least the following experience during the completion of the advanced internship:
(1) Applicant has completed at least a three hundred (300) hour advanced internship that enabled the applicant to provide direct mental health counseling services while under the supervision of one of the professionals listed below.

As an official of the school named above, I certify that the above-named applicant did receive the following supervision during the completion of the advanced internship:
Applicant received a minimum of one (1) hour per week of individual supervision and a minimum of one and one-half (1 1/2) hours per week of group supervision with other students, throughout the advanced internship. For the purposes of this certification, individual supervision is defined as supervision rendered to one (1) person at a time, and group supervision is supervision rendered to at least two (2) and not more than twelve (12) individuals at one (1) time. During the completion of this advanced internship, the applicant did receive the following number of hours of face-to-face supervision: _____

I further certify that a program faculty member conducted the supervision for this advanced internship, or a supervisor working under the supervision of a program faculty member using audiotape, videotape and/or direct observation. The applicant's supervisor(s) held the following position(s), degree(s), license(s), and/or certification(s) - [*Provide name(s) and qualification(s) below*]:

Program faculty member:	
Alternate supervisor:	
Site supervisor:	
I hold the following position at:	
Position held at the institution:	Name of institution
Name (*last, first, middle, maiden or previous name*)	

RETURN THIS FORM TO:
Health Professions Bureau
402 West Washington Street, Room 041
Indianapolis, IN 46204

FORM E2
VERIFICATION OF EXPERIENCE FOR LICENSURE AS A MENTAL HEALTH COUNSELOR (LMHC)

State Form 50319 (R / 1-02)

Complete **SECTION A** and then forward this form to your previous or current employer(s) for completion of **SECTION B**. You must submit proof that you have acquired at least 3,000 hours of post-graduate clinical experience over a two (2) year period of time. **This form may be duplicated if your 3,000 hours of experience have been completed at more than one place of employment.** If you are no longer able to contact your previous employer(s), you may complete **SECTION C** (*on the reverse side of this form*) for each previous place of employment. Sign the form(s) in the presence of the Notary Public and have your signature notarized, then return the form to the Health Professions Bureau at the address listed in the lower left hand corner of this form.

SECTION A / APPLICANT INFORMATION

Name of applicant (*last, first, middle, maiden*)	Social Security number *
Name of employer	Dates of employment (*month/year to month/year*)
Location of place of employment or place of practice	

SECTION B / EMPLOYER / EMPLOYMENT INFORMATION

This section is to be completed by the applicant's previous or current employer, notarized and sent directly to the Health Professions Bureau at the address listed in the lower left hand corner of this form.

Total number of months the above-named applicant served in the practice of mental health counseling: _____

Total number of hours served at the address below: _____

The above-named applicant was providing mental health counseling services directly to clients on an average of at least _____ hours per week, during the period of time he / she was in my employment.

Address(es) of where the above-named applicant provided the majority of his / her mental health counseling services:

_____

_____

I swear that the above information is true and correct to the best of my knowledge and belief.

SEAL OF NOTARY PUBLIC

_____
Signature of employer

_____
Printed name of employer

_____
Title

_____
Daytime telephone number

_____
Date (*month, day, year*)

RETURN THIS FORM TO:
Health Professions Bureau
402 West Washington Street, Room 041
Indianapolis, IN 46204

THIS IS A TWO-SIDED FORM

FORM E2
VERIFICATION OF EXPERIENCE FOR LICENSURE AS A MENTAL HEALTH COUNSELOR (LMHC)

State Form 50319 (R / 1-02)

SECTION C / AFFIRMATION OF EXPERIENCE

To be completed by applicant if the applicant's previous employer is no longer able to complete **SECTION B** (*on reverse side of this form*). Please indicate below the reason why your previous employer is no longer able to complete **SECTION B** (*on the reverse side of this form*). **If you are affirming experience acquired through more than one previous employer this form may be duplicated but you must submit one notarized AFFIRMATION OF EXPERIENCE for each previous employer that is no longer able to complete SECTION B (***on the reverse of this form***).**

I am unable to have my previous employer(s) complete SECTION B for the following reason:

☐ Deceased ☐ Unable to be located ☐ Other reason

If you have checked "Other reason", please briefly explain:

_____

_____

Total number of months that you have been providing mental health counseling services directly to clients on an average of at least _____ hours per week, at the address below: _____

Total number of hours served at the address below: _____

Period of time in which you provided these services: _____ (*month / year*) to _____ (*month / year*)

Name of facility and address where mental health counseling services were provided:

_____

_____

Provide the name of a professional colleague who can attest to the validity of the above statements:

_____ ( ) _____

Name of colleague (*last, first, middle, maiden*) Daytime telephone number of colleague

_____

Address of colleague

_____

List all graduate degrees, credentials and / or state board issued licenses / certifications held by this colleague

APPLICANT'S AFFIRMATION

(*To be completed only if applicant is unable to complete SECTION B***)**

_____ _____

Signature of applicant (*Sign only in the presence of the Notary Public*) Date (*month, day, year*)

Before me, the undersigned, a Notary Public for _____ County, State of _____

_____, personally appeared and acknowledged in the foregoing

(*Name of applicant*)

statements as true and correct to the best of his / her knowledge and belief this _____ day of _____, 20 _____ .

_____, Notary Public.

(*Signature of Notary Public*)

County of Residence: _____

My Commission Expires: _____

FORM S-2
VERIFICATION OF SUPERVISION FOR LICENSURE AS A MENTAL HEALTH COUNSELOR (LMHC)

State Form 50319 (R / 1-02)

Complete **SECTION A** and then forward this form to your previous or current supervisor(s) for completion of **SECTION B**. You must submit proof that you have received at least one hundred (100) hours of face to face supervision acquired during your 3,000 hours of post-graduate clinical experience. **This form may be duplicated if your one hundred (100) hours of face to face supervision have been completed through multiple supervisors..** If you are no longer able to contact your previous supervisor(s), you may complete **SECTION C** (*on the reverse side of this form*) for each previous supervisor. Sign the form(s) in the presence of the Notary Public and have your signature notarized, then return the form to the Health Professions Bureau at the address listed in the lower left hand corner of this form.

SECTION A / APPLICANT INFORMATION

Name of applicant (*last, first, middle, maiden*)	Social Security number *
Name of supervisor	Dates of supervision (*month/year to month/year*)

SECTION B / SUPERVISOR INFORMATION

This section is to be completed by the applicant's previous or current supervisor, notarized and sent directly from the applicant's previous or current supervisor to the Health Professions Bureau at the address listed in the lower left hand corner of this form.

Total number of hours of face to face supervision you provided to the above-named applicant: _____

The above-named applicant was providing mental health counseling services directly to clients at the time of my supervision?

☐ Yes ☐ No If No, please explain: _____

_____

I hold the following graduate degree(s), credential(s), and / or state board issued license(s) / certification(s) that qualify me to serve as a mental health counselor supervisor: _____

_____

I swear that the above information is true and correct to the best of my knowledge and belief.

SEAL OF NOTARY PUBLIC

_____
Signature

_____
Printed name

_____
Title

_____
Daytime telephone number

_____
Date (*month, day, year*)

RETURN THIS FORM TO:
Health Professions Bureau
402 West Washington Street, Room 041
Indianapolis, IN 46204

THIS IS A TWO-SIDED FORM

FORM S-2
VERIFICATION OF SUPERVISION FOR LICENSURE AS A MENTAL HEALTH COUNSELOR (LMHC)

State Form 50319 (R / 1-02)

SECTION C / AFFIRMATION OF SUPERVISION

To be completed by applicant if your previous supervisor is no longer able to complete **SECTION B** (*on reverse side of this form*). Please indicate below the reason why your previous supervisor is no longer able to complete **SECTION B** (*on the reverse side of this form*). **If you are affirming supervision received from more than one previous supervisor, this form may be duplicated but you must submit one notarized AFFIRMATION OF SUPERVISION for each previous supervisor that is no longer able to complete SECTION B (***on the reverse of this form***).**

Please indicate below the reason why your previous supervisor is no longer able to complete SECTION B.
My previous supervisor named below is:

☐ Deceased ☐ Unable to be located ☐ Other reason

If you have checked "Other reason", please explain:

_____

_____

Supervision was provided by: _____
(*Name of supervisor / last, first, middle, maiden*)

Total number of hours of face-to-face supervision you have received from this supervisor while providing mental health counseling services directly to clients: _____

Date of Supervision: _____ (*month / year*) to _____ (*month / year*)

List all graduate degrees, credentials and / or state board issued licenses / certifications that qualified this individual to serve as a mental health counselor supervisor: _____

_____

APPLICANT'S AFFIRMATION

(*To be completed only if applicant is unable to complete SECTION B***)**

_____ _____
Signature of applicant (*Sign only in the presence of the Notary Public*) Date (*month, day, year*)

Before me, the undersigned, a Notary Public for _____ County, State of _____

_____, personally appeared and acknowledged in the foregoing
(*Name of applicant*)

statements as true and correct to the best of his / her knowledge and belief this _____ day of _____, 20 _____.

_____, Notary Public.
(*Signature of Notary Public*)

County of Residence: _____

My Commission Expires: _____

ALL INFORMATION ON THIS FORM SHOULD BE TYPED OR CLEARLY WRITTEN.
THIS IS A TWO-SIDED FORM.

FORM EE
VERIFICATION OF EXPERIENCE FOR LICENSURE AS A MENTAL HEALTH COUNSELOR (LMHC)

State Form 50319 (R / 1-02)

TO BE USED ONLY IF YOU ARE APPLYING BY EXEMPTION FROM EXAMINATION.

Complete **SECTION A** and then forward this form to your previous or current employer(s) for completion of **SECTION B**. You must submit proof that you have been engaged in the practice of mental health counseling for not less than three (3) of the previous five (5) years. **This form may be duplicated if your three (3) years of experience have been completed at more than one place of employment.** If you are no longer able to contact your previous employer(s), or you have been in private practice, you may complete **SECTION C** (*on the reverse side of this form*) for each previous place of employment. Sign the form(s) in the presence of the Notary Public and have your signature notarized, then return the form to the Health Professions Bureau at the address **listed in the lower left hand corner of this form.**

SECTION A / APPLICANT INFORMATION

Name of applicant (*last, first, middle, maiden*)	Social Security number *
Name of employer	Dates of employment or practice (*month/year to month/year*)
Location of place of employment or place of practice	

SECTION B / EMPLOYER / EMPLOYMENT INFORMATION

This section is to be completed by the applicant's previous or current employer, notarized and sent directly from the applicant's previous or current employer to the Health Professions Bureau at the address listed in the lower left hand corner of this form.

Total number of months the above-named applicant served in the practice of mental health counseling: _____

Total number of hours served under my employment: _____

The above-named applicant was providing mental health counseling services directly to clients on an average of at least _____ hours per week, during the period of time he / she was in my employment.

Address(es) of where the above-named applicant provided the majority of his / her mental health counseling services:

_____

_____

I swear that the above information is true and correct to the best of my knowledge and belief.

SEAL OF NOTARY PUBLIC

_____
Signature of employer

_____
Printed name of employer

_____
Title

_____
Daytime telephone number

_____
Date (*month, day, year*)

RETURN THIS FORM TO:
Health Professions Bureau
402 West Washington Street, Room 041
Indianapolis, IN 46204

THIS IS A TWO-SIDED FORM

FORM EE
VERIFICATION OF EXPERIENCE FOR LICENSURE AS A MENTAL HEALTH COUNSELOR (LMHC)

State Form 50319 (R / 1-02)

TO BE USED ONLY IF YOU ARE APPLYING BY EXEMPTION FROM EXAMINATION.

SECTION C / AFFIRMATION OF EXPERIENCE

To be completed by applicant if the applicant was in private practice or if your previous employer is no longer able to complete **SECTION B** (*on reverse side of this form*). Please indicate below why your previous employer is no longer able to complete SECTION B. If you are affirming experience acquired through more than one previous employer this form may be duplicated but you must submit one notarized AFFIRMATION OF EXPERIENCE for each previous employer that is no longer able to complete SECTION B (*on the reverse of this form*).

I acquired this experience through private practice. ☐ Yes ☐ No

If you answered yes, then please proceed to Section C-2.
If you answered no, then please proceed to Section C-1.

SECTION C-1

I am unable to have my previous employer complete SECTION B for the following reason:

☐ Deceased ☐ Unable to be located ☐ Other reason

If you have checked "Other reason", please briefly explain:

_____

_____

SECTION C-2

Total number of months that you have been providing mental health counseling services directly to clients at the address below on an average of at least _____ hours per week: _____ Total number of hours served at the address below: _____

Period of time in which you provided these services: _____ (*month / year*) to _____ (*month / year*)

Name of facility and address where mental health counseling services were provided:

_____

_____

Provide the name of a professional colleague who can attest to the validity of the above statements:

_____ ( ) _____

Name of colleague (*last, first, middle, maiden*) Daytime telephone number of colleague

_____

Address of colleague

_____

List all graduate degrees, credentials and / or state board issued licenses / certifications held by this colleague

APPLICANT'S AFFIRMATION

(*To be completed only if applicant is unable to complete SECTION B***)**

_____ _____

Signature of applicant (*Sign only in the presence of the Notary Public*) Date (*month, day, year*)

Before me, the undersigned, a Notary Public for _____ County, State of _____

_____, personally appeared and acknowledged in the foregoing
(*Name of applicant*)

statements as true and correct to the best of his / her knowledge and belief this _____ day of _____, 20 _____.

_____, Notary Public.
(*Signature of Notary Public*)

County of Residence: _____ My Commission Expires: _____